# General

## Guideline Title

Clinical practice guideline: suicide risk assessment.

## Bibliographic Source(s)

ENA Emergency Nursing Resources Development Committee. Clinical practice guideline: suicide risk assessment. Des Plaines (IL): Emergency Nurses Association; 2012 Dec. 15 p. [45 references]

## Guideline Status

This is the current release of the guideline.

# Recommendations

## Major Recommendations

The grades of recommendations (A–C, Not Recommended), levels of evidence (I–VII), and quality of evidence (I–IV) are defined at the end of the "Major Recommendations" field.

Description of Decision Options/Interventions and the Level of Recommendation

*Please note that the references listed after each recommendation represent the evidence considered when making the recommendation. This does not mean that the evidence in each individual reference supports the recommendation.*

Initial Suicide Assessment

A. Suicide screening tools should be used as a part of the assessment process for appropriate emergency department (ED) patients (based upon presentation). Level A – High (Coristine et al., 2007; Gaynes et al., 2004; Holden et al., 1998; Jacobs et al., 2003; National Institute for Health and Care Excellence [NICE], 2011; Royal College of Nursing [RCN], 2009; Royal College of Psychiatrists [RCP], 2010; The Joint Commission [JC], 2012; Vergare et al., 2010)
B. The use of computer based tools for suicide risk assessment in the ED is feasible and acceptable to staff and for patients ages 11 and older. Level C – Weak (Choo et al., 2012; Fein et al., 2010; Gardner et al., 2010)
C. Screening for risk of suicide in pediatric patients over age 10 based upon presentation, is appropriate, feasible and practical in the ED. Level B – Moderate (DeMaso et al., 2009; Dolan & Fein, 2011; Gardner et al., 2010; Horowitz et al., 2010; NICE, 2011; Pailler et al., 2009)
D. Training ED personnel improves confidence in screening for suicide risk. Level B – Moderate (Currier et al., 2012; Dolan & Fein, 2011; NICE, 2011; RCN, 2009; RCP, 2010)

Suicide Risk Instruments

A. The Behavioral Health Screening-ED (BHS-ED); Mental Health Triage Scale (MHTS); Manchester Self-Harm Rule (MSHR); P4; and ReACT Self-Harm Rule are valid and feasible for initial assessment of suicide risk in the ED. Level B – Moderate (Cooper et al., 2006; Cooper et al., 2010; Dube et al., 2010; Fein et al., 2010; Happell, Summers, & Pinikahana, 2002; Randall, Colman, & Rowe, 2011; Steeg et al., 2012)
B. The following instruments are feasible, valid and reliable measures for use assessing risk for suicide in the ED setting. Level B – Moderate (see Table A, Appendix 1 in the original guideline document for further details):
    - Beck's Suicide Intent Scale (SIS)
    - Depressive Symptom Inventory-Suicidality Sub-scale (DSI-SS)
    - Geriatric Depression Scale (GDS) GDS-30/GDS-15/GDS-5
    - Risk Assessment Matrix (RAM)
    - Suicidal Ideation Questionnaire (SIQ)
    - Suicidal Ideation Questionnaire (SIQ-JR)
    - Violence and Suicide Assessment Form (VASA)
    - Nurses Global Assessment of Suicide Risk (NGASR)
    - Risk of Suicide Questionnaire (RSQ)
C. The following suicide risk instruments are not recommended for assessment of risk in the ED setting. Not recommended for practice (see Table B, Appendix 1 in the original guideline document for further details):
    - Beck Hopelessness Scale (BHS)
    - Beck Scale for Suicide Ideation (BSS)
    - Behavioral Activity Rating Scale (BARS)
    - Centers for Epidemiologic Studies Depression Scale (CES-D)
    - Centers for Epidemiologic Studies Depression Scale for Children (CES-DC)
    - Columbia Suicide Screen (CSS)
    - Death/Suicide Implicit Association Test (IAT)
    - General Health Questionnaire (GHQ-12)
    - Geriatric Suicide Ideation Scale (GSIS)
    - Modified SAD Persons Scale (MSPS)
    - Patient Health Questionnaire for Adolescents (PHQ-A)
    - SAD Persons Scale (SPS): S=Sex, A=Age, D=Depression, P=Previous Attempt, E=Ethanol Abuse, R=Rational Think Loss, S=Social Support lacking, O=Organized Plan, N=No Spouse, and S=Sickness all items = 1 point
    - Scale for Suicide Ideation (SSI)

Suicide Risk Predictors

A. Previous episodes of deliberate self-harm are a strong predictor of future suicide attempt. Level A – High (Bergen et al., 2010; Bilen et al., 2011; Haney et al., 2012; NICE, 2011; Steeg et al., 2012)
B. Screening for suicide risk should be a part of the assessment process based upon patient presentation, is appropriate, feasible and practical in the ED. Patients with the following presentations should be considered for screening:
    a. History of major depressive disorder (MDD) or post traumatic stress disorder (PTSD). Level B – Moderate (Bergen et al., 2010; Diefenbach, Wooley, & Goethe, 2009; Dube et al., 2010, Gardner et al., 2010; Haney et al., 2012, Warner et al., 2011)
    b. Chronic illness in adults. Level C – Weak (Haney et al., 2012; Ilgen et al., 2009; Oude Voshaar et al., 2011)
    c. Young female. Level C – Weak (Cooper et al., 2010; Diefenbach, Wooley, & Goethe, 2009; Gardner et al., 2010; Kuo, Gallo, & Tien, 2001)
    d. Males over 55 years of age. Level C – Weak (Joe & Niedermeier, 2006; Oude Voshaar et al., 2011)
    e. Lethal methods of self-harm with self-cutting being significantly associated with repeat episode. Level C – Weak (Bergen et al., 2010; Bergen et al., 2012; Haney et al., 2012; Steeg et al., 2012)
    f. Substance abuse. Level C – Weak (Haney et al., 2012; Ilgen et al., 2009; Ting et al., 2012)
    g. Binge or high episodic drinking for adolescents and young adults. Level C – Weak (Aseltine et al., 2009)
    h. Recent negative life events. Level C – Weak (Coristine et al., 2007; Horesh, Sever, & Apter, 2003; Joe & Niedermeier, 2006)
    i. Living alone. Level C – Weak (Ilgen et al., 2009; Steeg et al., 2012)
    j. Lower socioeconomic status. Level C – Weak (Ilgen et al., 2009; Murphy et al., 2011; Zhang et al., 2005)

Definitions:

Levels of Recommendation for Practice

Level A Recommendations: High

- Reflects a high degree of clinical certainty
- Based on availability of high quality Level I, II and/or III evidence available using Melnyk & Fineout-Overholt grading system* (see the "Rating Scheme for the Strength of the Evidence" field)
- Based on consistent and good quality evidence; has relevance and applicability to emergency nursing practice
- Is beneficial

Level B Recommendations: Moderate

- Reflects moderate clinical certainty
- Based on availability of Level III and/or Level IV and V evidence using Melnyk & Fineout-Overholt grading system* (see the "Rating Scheme for the Strength of the Evidence" field)
- There are some minor flaws or inconsistencies in quality of evidence; has relevance and applicability to emergency nursing practice
- Is likely to be beneficial

Level C Recommendations: Weak

- Level V, VI and/or VII evidence available using Melnyk & Fineout-Overholt grading system* (see the "Rating Scheme for the Strength of the Evidence" field)
- Based on consensus, usual practice, evidence, case series for studies of treatment or screening, anecdotal evidence, and/or opinion
- There is limited or low quality patient-oriented evidence; has relevance and applicability to emergency nursing practice
- Has limited or unknown effectiveness

Not Recommended for Practice

- No objective evidence or only anecdotal evidence available; or the supportive evidence is from poorly controlled or uncontrolled studies
- Other indications for not recommending evidence for practice may include:
    - Conflicting evidence
    - Harmfulness has been demonstrated
    - Cost or burden necessary for intervention exceeds anticipated benefit
    - Does not have relevance or applicability to emergency nursing practice
- There are certain circumstances in which the recommendations stemming from a body of evidence should not be rated as highly as the individual studies on which they are based. For example:
    - Heterogeneity of results
    - Uncertainty about effect magnitude and consequences
    - Strength of prior beliefs
    - Publication bias

Grading the Levels of Evidence*

I. Evidence from a systematic review or meta-analysis of all relevant randomized controlled trials (RCTs) or evidence-based clinical practice guidelines based on systematic reviews of RCTs
II. Evidence obtained from at least one properly designed RCT
III. Evidence obtained from well-designed controlled trials without randomization
IV. Evidence obtained from well-designed case control and cohort studies
V. Evidence from systematic reviews of descriptive and qualitative studies
VI. Evidence from a single descriptive or qualitative study
VII. Evidence from opinion of authorities and/or reports of expert committees

Grading the Quality of the Evidence

I. Acceptable Quality: No concerns
II. Limitations in Quality: Minor flaws or inconsistencies in the evidence

III. Major Limitations in Quality: Many flaws and inconsistencies in the evidence
IV. Not Acceptable: Major flaws in the evidence

*Melnyk, B. M., & Fineout-Overholt, E. (2005). Evidence-based practice in nursing and healthcare: A guide to best practice. Philadelphia, PA: Lippincott, Williams, & Wilkins.

### Clinical Algorithm(s)

None provided

## Scope

### Disease/Condition(s)

Suicidal ideation

### Guideline Category

Prevention

Risk Assessment

Screening

### Clinical Specialty

Emergency Medicine

Nursing

Psychiatry

Psychology

### Intended Users

Advanced Practice Nurses

Emergency Medical Technicians/Paramedics

Hospitals

Nurses

Physician Assistants

Physicians

Psychologists/Non-physician Behavioral Health Clinicians

Social Workers

### Guideline Objective(s)

To evaluate what risk assessment tools and predictors are effective in screening for self-harm or suicidal ideation during initial assessment of patients across the life span in the emergency care setting

## Target Population

Patients who present to the emergency setting who have suicidal ideation or after attempted suicide and/or those patients at high risk for future attempts of suicide

## Interventions and Practices Considered

1. Training to improve the confidence of emergency department (ED) personnel in screening patients for suicide risk
2. Instruments used to assess potential suicide/self-harm risk*
    - Mental Health Triage Scale (MHTS)
    - Behavioral Health Screening-Emergency Department (BHS-ED)
    - Manchester Self-Harm Rule
    - ReACT Self-Harm Rule
    - P4 screener
3. Awareness and consideration of predictors for suicide, including demographics, prior psychiatric and medical history, and significant life events

*A summary of additional instruments may be viewed in Appendix 1 in the original guideline document; the "Major Recommendations" field of this summary also provides a list of instruments that are recommended/not recommended for ED use.

## Major Outcomes Considered

- Accuracy, sensitivity, and specificity of suicide risk assessment instruments
- Risk factors for suicide
- Prevalence of suicidality

# Methodology

## Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

## Description of Methods Used to Collect/Select the Evidence

Via a comprehensive literature search, all articles relevant to the topic were identified. The following resources were searched: PubMed, Google Scholar, MEDLINE, Cumulative Index to Nursing and Allied Health Literature (CINAHL), OVID, TRIP Data Base, HAPI, Cochrane - British Medical Journal, Agency for Healthcare Research and Quality (AHRQ; www.ahrq.gov), and the National Guideline Clearinghouse (www.guideline.gov). Searches were conducted using a variety of different search term combinations. These included initial psychiatric emergencies, behavioral health emergency and mental health emergency. Additional search terms were assessment, management with the filters "and" and "or" added. Finally, the topics searched included suicide, suicidal ideation, suicide assessment, suicide scales and/or tools, and suicide predictors. Initial searches were limited to English language articles from 2000 to 2012. The reference lists in the selected articles were hand searched for additional pertinent references. Research articles from emergency department (ED) settings, non-ED settings, emergency care settings, position statements and guidelines from other sources were also reviewed. Articles that did not address the Population, Intervention, Comparison and Outcomes (PICO) question were excluded for the purpose of this systematic review of evidence. Other

articles that evaluated specific medications or mental health pathology, such as schizophrenia were not included.

Articles that met the following criteria were chosen to formulate the clinical practice guideline (CPG): research studies, meta-analyses, systematic reviews, and existing guidelines relevant to the topic of suicide risk assessment.

## Number of Source Documents

53 documents were included in the evidence tables.

## Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

## Rating Scheme for the Strength of the Evidence

Grading the Levels of Evidence*

I. Evidence from a systematic review or meta-analysis of all relevant randomized controlled trials (RCTs) or evidence-based clinical practice guidelines based on systematic reviews of RCTs
II. Evidence obtained from at least one properly designed RCT
III. Evidence obtained from well-designed controlled trials without randomization
IV. Evidence obtained from well-designed case control and cohort studies
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*Melnyk, B. M., & Fineout-Overholt, E. (2005). Evidence-based practice in nursing and healthcare: A guide to best practice. Philadelphia, PA: Lippincott, Williams, & Wilkins.

## Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review with Evidence Tables

## Description of the Methods Used to Analyze the Evidence

The clinical practice guideline (CPG) authors used a standardized reference table to collect information and assist with preparation of tables of evidence ranking each article in terms of the level of evidence, quality of evidence, and relevance and applicability to practice. Clinical findings and levels of recommendations regarding patient assessment were then made by the 2012 Emergency Nursing Resources Development Committee according to Emergency Nurses Association (ENA)'s classification of levels of recommendation for practice, which include: Level A High, Level B Moderate, Level C Weak or Not recommended for practice (see the "Rating Scheme for the Strength of the Recommendations" field).

## Methods Used to Formulate the Recommendations

Expert Consensus

## Description of Methods Used to Formulate the Recommendations

This clinical practice guideline (CPG) was created based on a thorough review and critical analysis of the literature following Emergency Nurses Association (ENA)'s Guidelines for the Development of Clinical Practice Guidelines (see the "Availability of Companion Documents" field).

Conference calls with Subcommittee members and staff are held as necessary to discuss progress and facilitate the Subcommittee's work. All members of the Subcommittee independently complete an exhaustive review of all identified literature, complete a separate evidence table for each topic (if possible), and then reconvene to reach consensus. Each Subcommittee prepares a description of the topic, definition, background, significance, and evidence table. The Subcommittee identifies and assigns preliminary scores for quality and strength of evidence, and describes conclusions based on the review of the body of evidence. Each Subcommittee also serves as "second readers" for another topic; this assures an in-depth look at the literature by two Subcommittees. The entire Committee reads the articles and reviews the evidence-appraisal tables for each topic and then finalizes implications for practice and the level of recommendation.

## Rating Scheme for the Strength of the Recommendations

Levels of Recommendation for Practice

Level A Recommendations: High

- Reflects a high degree of clinical certainty
- Based on availability of high quality Level I, II and/or III evidence available using Melnyk & Fineout-Overholt grading system* (see the "Rating Scheme for the Strength of the Evidence" field)
- Based on consistent and good quality evidence; has relevance and applicability to emergency nursing practice
- Is beneficial

Level B Recommendations: Moderate

- Reflects moderate clinical certainty
- Based on availability of Level III and/or Level IV and V evidence using Melnyk & Fineout-Overholt grading system* (see the "Rating Scheme for the Strength of the Evidence" field)
- There are some minor flaws or inconsistencies in quality of evidence; has relevance and applicability to emergency nursing practice
- Is likely to be beneficial

Level C Recommendations: Weak

- Level V, VI and/or VII evidence available using Melnyk & Fineout-Overholt grading system* (see the "Rating Scheme for the Strength of the Evidence" field)
- Based on consensus, usual practice, evidence, case series for studies of treatment or screening, anecdotal evidence, and/or opinion
- There is limited or low quality patient-oriented evidence; has relevance and applicability to emergency nursing practice
- Has limited or unknown effectiveness

Not Recommended for Practice

- No objective evidence or only anecdotal evidence available; or the supportive evidence is from poorly controlled or uncontrolled studies
- Other indications for not recommending evidence for practice may include:
    - Conflicting evidence
    - Harmfulness has been demonstrated
    - Cost or burden necessary for intervention exceeds anticipated benefit
    - Does not have relevance or applicability to emergency nursing practice
- There are certain circumstances in which the recommendations stemming from a body of evidence should not be rated as highly as the individual studies on which they are based. For example:
    - Heterogeneity of results
    - Uncertainty about effect magnitude and consequences
    - Strength of prior beliefs
    - Publication bias

*Melnyk, B. M., & Fineout-Overholt, E. (2005). Evidence-based practice in nursing and healthcare: A guide to best practice. Philadelphia, PA: Lippincott, Williams, & Wilkins.

## Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

## Method of Guideline Validation

Internal Peer Review

## Description of Method of Guideline Validation

The Institute for Emergency Nursing Research (IENR) Advisory Council reviews the final document for overall validity and provides feedback as appropriate using the Clinical Practice Guidelines (CPGs) Evaluation Worksheet. Reviews and feedback are sent to the Subcommittee to evaluate and incorporate, as appropriate. Emergency Nurses Association (ENA) staff creates the final products for publication with input from the Committee.

# Evidence Supporting the Recommendations

## References Supporting the Recommendations

Aseltine RH Jr, Schilling EA, James A, Glanovsky JL, Jacobs D. Age variability in the association between heavy episodic drinking and adolescent suicide attempts: findings from a large-scale, school-based screening program. J Am Acad Child Adolesc Psychiatry. 2009 Mar;48(3):262-70. PubMed

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Choo EK, Ranney ML, Aggarwal N, Boudreaux ED. A systematic review of emergency department technology-based behavioral health interventions. Acad Emerg Med. 2012 Mar;19(3):318-28. PubMed

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Gaynes BN, West SL, Ford CA, Frame PS, Klein J, Lohr KN. Screening for suicide risk: systematic evidence review for the U.S. Preventive Services Task Force. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2004 May 1. 100 p. (Systematic Evidence Review; no. 32). [99 references]

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### Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for each recommendation (see the "Major Recommendations" field).

## Benefits/Harms of Implementing the Guideline Recommendations

### Potential Benefits

Appropriate suicide risk assessment to determine which patients are in emergent or urgent need of mental health care so that appropriate safety interventions can be implemented

### Potential Harms

Not stated

## Qualifying Statements

### Qualifying Statements

- The Emergency Nurses Association (ENA)'s Clinical Practice Guidelines (CPGs) are developed by ENA members to provide emergency nurses with evidence-based information to utilize and implement in their care of emergency patients and families. Each CPG focuses on a clinical or practice-based issue, and is the result of a review and analysis of current information believed to be reliable. As such, information and recommendations within a particular CPG reflect the current scientific and clinical knowledge at the time of publication, are only current as of their publication date, and are subject to change without notice as advances emerge.
- In addition, variations in practice, which take into account the needs of the individual patient and the resources and limitations unique to the institution, may warrant approaches, treatments and/or procedures that differ from the recommendations outlined in the CPGs. Therefore, these recommendations should not be construed as dictating an exclusive course of management, treatment or care, nor does the use of such recommendations guarantee a particular outcome. CPGs are never intended to replace a practitioner's best nursing judgment based on the clinical circumstances of a particular patient or patient population. CPGs are published by ENA for educational and informational purposes only, and ENA does not approve or endorse any specific methods, practices, or sources of information. ENA assumes no liability for any injury and/or damage to persons or property arising out of or related to the use of or reliance on any CPG.

## Implementation of the Guideline

### Description of Implementation Strategy

An implementation strategy was not provided.

## Implementation Tools

Quick Reference Guides/Physician Guides

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

# Institute of Medicine (IOM) National Healthcare Quality Report Categories

## IOM Care Need

Living with Illness

Staying Healthy

## IOM Domain

Effectiveness

Patient-centeredness

Timeliness

# Identifying Information and Availability

## Bibliographic Source(s)

ENA Emergency Nursing Resources Development Committee. Clinical practice guideline: suicide risk assessment. Des Plaines (IL): Emergency Nurses Association; 2012 Dec. 15 p. [45 references]

## Adaptation

Not applicable: The guideline was not adapted from another source.

## Date Released

2012 Dec

## Guideline Developer(s)

Emergency Nurses Association - Professional Association

## Source(s) of Funding

Emergency Nurses Association

## Guideline Committee

2012 ENA Emergency Nursing Resources Development Committee

## Composition of Group That Authored the Guideline

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## Financial Disclosures/Conflicts of Interest

Not stated

## Guideline Status

This is the current release of the guideline.

## Guideline Availability

Electronic copies: Available in Portable Document Format (PDF) from the Emergency Nurses Association Web site .

## Availability of Companion Documents

The following are available:

- Requirements for the development of: clinical practice guidelines, clinical practice guidelines synopsis, and translation into practice (TIP) recommendations. Des Plaines (IL): Emergency Nurses Association; 2013 Dec. 40 p. Electronic copies: Available in Portable Document Format (PDF) from the Emergency Nurses Association Web site .
- Clinical practice guideline: suicide risk assessment. Synopsis. Des Plaines (IL): Emergency Nurses Association; 2012 Dec. 1 p. Electronic copies: Available in PDF from the Emergency Nurses Association Web site .
- CPG evidence table: suicide risk assessment. Des Plaines (IL): Emergency Nurses Association; 2012 Dec. 34 p. Electronic copies: Available in PDF from the Emergency Nurses Association Web site .
- CPG other resources table: suicide risk assessment. Des Plaines (IL): Emergency Nurses Association; 2012 Dec. 1 p. Electronic copies: Available in PDF from the Emergency Nurses Association Web site .

## Patient Resources

None available

## NGC Status

This NGC summary was completed by ECRI Institute on February 13, 2014. The information was verified by the guideline developer on March 27, 2014.

## Copyright Statement

# Disclaimer

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